

February 12, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2238-P
P.O. Box 8015
Baltimore, MD 21244-8015

RE: Comments on proposed rule Medicaid Program; Prescription Drugs
71 Federal Register 77174 (December 22, 2006); File Code: CMS-2238-P

Dear Ms. Norwalk,

As Chair and on behalf of the Tribal Technical Advisory Group (TTAG), I would like to thank you for the opportunity to provide comments to the proposed regulations, published in the Federal Register on December 22, 2006, at Vol. 71, No. 246, implementing provisions of the Deficit Reduction Act (DRA) pertaining to prescription drugs under the Medicaid program.

It is our understanding that this proposed rule, in part, will limit State Medicaid expenditures for certain multiple source drugs. States will retain the authority to set their own reimbursement levels and dispensing fees paid to pharmacists, and may pay above or below the Federal upper payment limit (FUL) as long as overall payments for drugs subject to a FUL are under the annual aggregate cap. About 600 drugs are initially subject to the FULs, including drugs for the treatment of asthma, hypertension, pain relief, and depression. States can vary reimbursement levels and can, for example, target more favorable reimbursement to pharmacists in rural or inner city areas or to independent pharmacists. To implement these regulations, each State must amend their State Medicaid Plan and describe their approach.

The Indian Health Service (IHS) and tribally operated pharmacies have authority to dispense, bill, and receive reimbursement from State Medicaid agencies for drugs prescribed to Medicaid beneficiaries. The State Medicaid agencies reimburse IHS and tribal pharmacies at cost per a payment methodology outlined in the State plan. IHS and tribal programs depend on the Medicaid reimbursements to supplement existing IHS appropriations to the IHS and tribal programs that are currently under funded. Many of these pharmacies are small and operate in remote rural areas. As such, any changes in Medicaid reimbursements can have a negative effect on their financial sustainability. The complexities of Indian health financing make it imperative that States consult with Tribes before and during the development of any amendments to their state plans. Without this consultation, implementation of this rule may have unintended negative consequences on Indian health programs.

On November 9, 2006 Dennis Smith, Director, Centers for Medicaid and State Operations issued a State Medicaid Directors' letter, SMDL #06-023. This letter encourages States to consult with Indian Tribes when implementing Deficit Reduction Act and submitting State Medicaid plan amendments. Specifically the letter states:

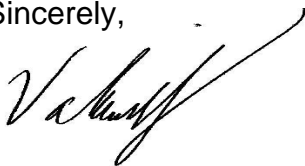
“In light of the new Deficit Reduction Act of 2005 (DRA) and our continued desire for Medicaid programs to effectively serve Tribal communities, CMS is taking this opportunity to again encourage States to consult with Tribes in open, good faith dialogue, as a number of provisions within the DRA have the potential to impact Tribes and American Indian and Alaska Native (AI/AN) Medicaid beneficiaries. Given the States' new flexibility to change their Medicaid programs through State Medicaid plans rather than through Medicaid demonstrations, maintaining ongoing communication between States and Tribes in the redesign of Medicaid programs and services is even more important...CMS strongly encourages all States to consult with Tribes as they implement the DRA.”

Consistent with CMS policy, we are requesting that CMS insert language in the final rule that would specifically remind States to consult with Tribes in the development of any State plan amendment to modify existing payment methodologies for prescription drug reimbursements. This reminder will allow each Tribe the opportunity to work with the State to assess local impacts and identify options prior to submission of State Plan amendments.

We are also requesting that CMS insert language in the final rule to encourage States to maintain their current level/type of reimbursement and filling fees to Tribal and IHS pharmacies because they are important safety net providers and will be harmed by the reductions. Because of the limited capacity of many Tribal and IHS pharmacies, and their dependence on prescription drug reimbursements to meet overhead and administrative costs, we believe that implementation of this proposed rule will result in Tribal and IHS pharmacies shouldering a disproportionate share of Medicaid prescription drug reductions. Tribal and IHS providers should be explicitly recognized as essential safety net pharmacies.

Thank you for your thoughtful consideration of my comments.

Sincerely,

A handwritten signature in black ink, appearing to read 'Val Davidson', with a long, sweeping flourish extending to the right.

Valerie Davidson, Chair
Tribal Technical Advisory Group